Preliminary Draft

Mental Health Services Chapter

District of Columbia State Health Systems Plan

State Health Planning and Development Agency
District of Columbia
Department of Health

MENTAL HEALTH SERVICES

TABLE OF CONTENTS

TITLE **PAGE**

MENTAL HEALTH SERVICES

I. INTRODUCTION

The District of Columbia public mental health system and the non-government/private sector are continuously developing the types and quantities of services needed for individuals diagnosed with mental illness and who are in need of services. For adults 22 years and older, these diagnoses can include schizophrenia, affective-disorder, manic-depressive disorder, severe forms of major depression and panic disorder. Children from birth to age 21 disturbance present most often with the diagnosis of Mood Disorders and Disruptive Behavior Disorders. They are diagnosed with mental illnesses, which result in functional impairments that interfere with their assumption of roles in the family, school, and other settings.

The Department of Mental Health (DMH) is in the process of developing a new system of services. This system will allow individuals with mental illness and emotional disturbance to choose among a variety of services that have been designed for the purpose of providing the necessary supports for them to function in their communities successfully.

II. BACKGROUND AND TRENDS

A. Government Sector

Court Ordered Plan

The U.S. District Court for the District of Columbia established the Transitional Receivership on March 6, 2000. A Transitional Receiver was named and charged with 1) developing a plan for the future direction and development of the public mental health system in the District and 2) certifying to the court at the conclusion of the probationary period the extent to which the District had the capacity to implement and was implementing the Final Court-Ordered Plan. The Transitional Receiver determined that while significant progress had been made, the incomplete status of several key initiatives warranted an extension of the probationary period. Therefore the Transitional Receiver requested and received updated information on an ongoing basis from DMH on the key outstanding areas of concern.

Based on the progress reported and information received, the Transitional Receiver certified to the court that the District has the capacity to implement and is implementing the Final Court-Ordered Plan. The Transitional Receiver also recommended that the court set a date for the end of the probationary period, and that the court terminate the receivership and all of the orders relating to the receiverships. In addition to ending the receivership, the Transitional Receiver also recommended that the court adopt the Exit Criteria and Methodology that was agreed upon by the parties.

The end of the receivership marked the end of the appointment of the Transitional Receiver. The court then appointed the Transitional Receiver as Monitor of the District's compliance with the

Order and the Plan. The Monitor's duties include observing, monitoring, reporting on the status of compliance with the Plan, and making recommendations to the court and to the parties concerning steps that should be taken to achieve compliance with the Plan.

The Department of Mental Health Structure

The Department of Mental Health (DMH), created in December 2001 is a cabinet-level agency. The Director of DMH reports to the Office of the Mayor of the District of Columbia. The primary mission of DMH is to address the mental health services and support the needs of District residents. To accomplish this mission, DMH is structured with a meaningful separation between its Authority role (policy maker for the mental health system) and its provider components (D.C. Community Services Agency and Saint Elizabeths Hospital) .

The Mental Health Authority

The mental health authority supports the overall administrative mission of DMH, and encompasses the global functions necessary to support the overall system. The Authority is responsible for establishing global priorities and strategic initiatives for DMH, as well as the coordination points for fiscal services, accountability, information systems, and service delivery development.

The Mental Health Authority's role involves planning and policy development, certification of qualified service providers, licensure of mental health facilities, quality improvement, provider oversight, administration of the Mental Health Rehabilitation Services (MHRS), development of systems of care for adults, children and youth, enforcement of consumer rights, and organizational development and training.

In addition, the Authority acts as an agent of the Medical Assistance Administration (MAA) in receiving and adjudicating claims for services provided. It assumes the responsibility for reimbursing providers for services rendered, and reconciles with Medicaid for the Federal Funds Portion (FFP) of those claims for services provided to Medicaid-eligible consumers.

The Authority also functions as a regulatory body through which certification will be sought by any provider seeking to provide Mental Health Rehabilitation Services (MHRS). The MHRS system includes nine services provided by DMH-certified, community-based providers.

In addition, the Department purchases 10 other District-funded services, such as residential services, homeless services, and clubhouse services, and employment services. The Department is in the process of converting these partially grant-funded services into a District-funded fee-for-service MHRS complementing the Medicaid-funded services.

a. Core Services Agencies

The Department of Mental Health has established the MHRS program to deliver a wide-array of intensive, community-based services for eligible adults and children through a provider network. DMH now certifies providers to deliver nine Medicaid services. Four of the MHRS are classified as core services (diagnostic/assessment, medication/somatic treatment, counseling, and community

support) and must be offered by a DMH-certified Core Services Agency or a DMH-certified sub-provider. Five of the MHRS (crisis/emergency, rehabilitation, intensive day treatment, community-based intervention, assertive community treatment) are classified as specialty services and must be offered by a DMH-certified specialty provider.

To date, 14 Core Services Agencies (CSAs), including the District-operated D.C. Community Services Agency and a number of specialty and sub-provider agencies have been certified. The public and private non-profit providers serve as the backbone of the District's comprehensive, community-based system for providing services to persons with serious mental illness.

The objective of each CSA is to create a clinical home for each person receiving DMH services, ensuring a single point of accountability for service delivery. The CSA model ensures that each person has an individualized recovery plan that clearly identifies the treatment goal and the services necessary to achieve these goals. This plan and service model is focused on a strengths and rehabilitative approach to each consumer's recovery.

DMH will certify any willing provider who meets the MHRS standards that DMH published as final regulation in November 2001. These standards reflect DMH's commitment to developing a network of providers that share DMH's mission to create high quality, easily accessible, recovery-based, consumer driven services. See **Table 1** for a list of providers and their certification date and services.

Table 1. Certified Mental Health Rehabilitation Services (MHRS) Providers And Dates of Certification

PROVIDER	DATE OF CERTIFICATION	CERTIFIED SERVICES
Northwestern Human Services	3/1/02	Specialty Provider/ACT, CBI
Anchor Mental Health Association	4/1/02	CSA/Rehab-Day Tx.
Green Door	4/1/02	CSA/All Core Services
D.C. Community Services Agency	4/1/02	CSA/Rehab-Day Tx., ACT, Crisis Emergency, CBI
Woodley House	4/1/02	CSA/All Core Services
Lutheran Social Services NCA	4/1/02	CSA
Community Connections, Inc.	5/1/02	CSA/ACT, CBI, Rehab-Day Tx.
Psychotherapeutic Outreach Services	5/1/02	CSA/ACT
Coates and Lane	5/1/02	CSA/All Core Services
Hillcrest Children Center	5/1/02	CSA/Crisis Emergency, CBI
Psychiatric Center Chartered, Inc.	8/1/02	CSA/ Rehab-Day Tx.
McClendon Center	8/1/02	Specialty Provider/Rehab-Day Tx.

PROVIDER	DATE OF CERTIFICATION	CERTIFIED SERVICES
Center for Mental Health	8/1/02	CSA/Rehab-Day Tx.
WHC/Behavioral Health Service	9/1/02	CSA/IDT
Deaf Reach	10/1/02	Subprovider/Diagnostic/Assessment, Counseling/Psychotherapy, Community Support Services
Life Stride, Inc.	12/1/02	CSA/Rehab-Day Tx.
First Home Care Corporation	1/1/03	CSA/CBI

b. Access Help-Line

Consumer access to services is critical. DMH has established the 24/7 Access Help- Line to allow consumers to receive information and for consumer referral on an emergency and non-emergency basis. The emergency mental health services have been redesigned as 24/7 comprehensive psychiatric emergency services. Psychiatric emergency services components include access, assessment, on-site and mobile crisis intervention, treatment planning, and linkage to services.

c. Residential Treatment Center Certification

The DMH has assumed responsibility for certifying residential treatment centers for children and youth, and is in the process of assuming this responsibility for the free standing mental health clinics and mental health day treatment programs in the District, formerly certified by the Department of Health Medical Assistance Administration. DMH will have sole responsibility for determining whether these facilities meet federal and District regulations for financial participation in the Medicaid program and will coordinate with the Medical Assistance Administration. The aim is to achieve better cost control and in particular better tracking of children served under the Medicaid program.

d. Licensing Community Residential Facilities

In addition, DMH has assumed responsibility for licensing mental health community residential facilities. The procedures to carry out licensing are in place along with the procedures for processing of initial and renewal licenses. DMH also has responsibility for monitoring these facilities and investigating complaints and unusual incidents.

e. Billing and HIPAA

Enhancements to the DMH infrastructure are ongoing. During fiscal year 2002, a community provider billing system to support the change to fee-for-service reimbursement was implemented. DMH continues to assess compliance with the new regulations governing the Health Insurance Portability and Accountability Act (HIPAA). A major undertaking is the implementation of the D.C. Wide Area Network in conjunction with the District's Office of the

Chief Technology Officer. There are 17 community sites undergoing conversion along with Saint Elizabeths Hospital. The DMH is the recipient of a Substance Abuse and Mental Health Services Administration, Center for Mental Health Services Data Infrastructure grant and activities to implement this grant have occurred.

f. Community Crisis Support Network

The DMH received approximately $2 million to develop the means to better assist District residents in emergencies, crises and disasters as experienced following the terrorist attacks of September 11, 2001. DMH has used the federal funds to establish a volunteer-based Community Crisis Support Network that is linked with existing District volunteer emergency services. An extensive emergency preparedness public awareness campaign has been developed to provide information to increase District residents' preparedness for future events.

g. Federal Grants

During fiscal year 2002, DMH was actively involved in a number of federal grant activities. The DMH entered into a no-cost extension for the Center for Mental Health Services 16 State Indicator Grant Project. This project has allowed the District to be among several states to pilot performance indicators that have been selected for their significance in mental health while attempting to establish comparability across states in the reporting of data. The DMH also applied for PATH grant funds to support a Drop-In Center and to support housing services. The DMH has been the recipient of and has applied for funding from a number of federal, local and private foundations (e.g., Substance Abuse and Mental Health Services Administration, Juvenile Justice, D.C. Department of Employment Services, Johnson and Johnson Foundation). These grants have supplemented projects related to supported competitive employment and the system of care for children/youth and their families including diversion from the juvenile justice system.

h. Cultural Competency Advisory Committee

The DMH also developed an action plan to enable the mental health system to become culturally competent to assure the delivery of quality services to the District's diverse cultural, linguistic, racial and ethnic populations. A 25-member Cultural Competency Advisory Committee was created to guide this new initiative. In addition, a baseline assessment of cultural competence was implemented in the Authority.

i. *Advisory Bodies*

DMH Partnership Council- The DMH Director established a Partnership Council in August 2001. This Council serves as an active advisory board, providing advice and direction on key policy issues, such as the annual budget, the annual strategic plan, proposed rules and standards, and other major program initiatives or policy changes. Currently there are 25 individuals on the Council. These individuals are representative of the various geographic areas of the District and a range of interests and perspectives concerning mental health priorities, programs and practices.

To ensure that the voices of consumers are heard at the highest levels, 51% of the persons serving on the Partnership Council are primary consumers or secondary consumers (family members) of system services. The Council reflects the varying interests of adults and children, youth and families. The Council also formalized a relationship with the Mayor's State Mental

Health Planning Council, which performs specific mental health planning activities necessary to conform to federal law.

State Mental Health Planning Council- The Mayor of the District of Columbia has historically appointed a citizen advisory group to oversee the public mental health system that includes consumers, family members, providers, advocates, concerned citizens, and District agencies. This group is now known as the State Mental Health Planning Council and is responsible for carrying out District and federal mandates that include: advocating for the mental health needs (services and resources) of adults with serious mental illness and children/youth with serious emotional disturbances, educating the public about mental illness and recovery, and reviewing the District's State Mental Health Plan and developing recommendations related to the plan.

The Mental Health Establishment Act of 2001, which established DMH, mandates that the Council Chair serve as a member of the System of Mental Health Care Sub-Council of the District's Inter-governmental Youth Investment Collaborative. Several members of the Council serve on the DMH Director's Partnership Council. The Council has established quarterly meetings with the Director of DMH to update the Council on issues that impact the mental health service delivery system for residents of the District of Columbia. The Council identified s issues of interest and/or concern that the Director, Department of Mental Health should address.

j. Interagency Collaboration
DMH has established ongoing collaborative relationships with public and private community providers; child/youth and family organizations; housing developers and providers; the interfaith community; District, regional and federal agencies; and others.

Currently, DMH has established relationships with a number of District agencies. These include the D.C. Public Schools (DCPS), Child and Family Services Agency (CFSA), Youth Services Administration (YSA), Medical Assistance Administration (MAA), Addiction Prevention and Recovery Administration (APRA), Maternal and Family Health Administration (MFHA), Mental Retardation and Developmental Disabilities Administration (MRDDA), D.C. Housing Authority (DCHA), and D.C. Housing and Community Development (DCHCD). The DMH is also participating in the Mayor's Neighborhood Services initiative along with other agencies.

The D.C. Community Services Agency

The Department of Mental Health Establishment Amendment Act of 2001, which established the Department of Mental Health (DMH), mandates oversight of the D.C. Community Services Agency. The Act states that DMH shall "directly operate one Core Services Agency, for three years from the effective date of this Act or longer, as needed, to address the community mental health needs of the residents of the District". The DMH, therefore, serves as the governing authority for the D.C. Community Services Agency.

In addition to being a certified Core Services Agency, the D.C. Community Services Agency is a certified to provide specialty services. These include:

- Rehabilitation/Day Services – services provided to adult consumers who are in need of a facility-based, structured clinical program;
- Community-Based Intervention Services – services provided to children, youth and their families who are in need of intense time-limited services;
- Crisis Emergency Services/Comprehensive Psychiatric Emergency Program (CPEP) Services – provide services to children, youth and adults experiencing a psychiatric emergency. The program minimizes risk and promotes safety for the consumer, staff, and the community at large, and
- Assertive Community Treatment Services - provide a full array of comprehensive, community-based mental health around the clock to help consumers lessen their symptoms of mental illness and remain in the community.

Community Support Teams that will spend 50% of their time with clients in natural settings will provide both adult and children's mental health services. These teams, consisting of a group of mental health providers, will be considered the "clinical home" for a designated number of mental health consumers.

The teams will provide diagnostic/assessment, counseling, community support (case management), medication and psychiatric services. Consumers can make contact with their clinical team on a 24-hour basis, seven days a week through an extensive after-hours On-Call system. The D.C. Community Services Agency has also added late evening and weekend hours for clinic-based services. All of these services will be accessed through a single community services information number, which is currently under development.

The Saint Elizabeths Hospital

Saint Elizabeths Hospital (SEH) is now a separate organization within the authority and operates under its own Chief Operating Officer. Clinical Managers interface with hospital staff in order to assure continuity of care and to reduce the number and length of stay for acute hospitalizations. The CSAs are responsible for coordinating consumers' return to the community and are mandated to work closely with the consumer and SEH and other community treatment teams to minimize the length of hospitalization.

Saint Elizabeths Hospital currently provides forensic inpatient services and acute and long-term care for non-forensic adults. The Hospital will gradually move toward the sole provision of tertiary care (3-12 months) for individuals who need the structure and security of a public mental hospital. Acute care, as planned, will primarily be provided under agreements with local hospitals. Forensic inpatient services will continue to be provided at Saint Elizabeths Hospital.

Adults requiring treatment in a 24-hour inpatient setting may receive services at Saint Elizabeths Hospital. The three primary programs at Saint Elizabeths are Adult Care, Continuing Care, and Forensic Services. The Acute Care Program currently consists of 92 beds (4 units); two units for all admissions, most of whom are stabilized within 14 days; and two units for patients who require treatment beyond 14 days for stabilization. The Continuing Care Program has 213 beds and provides ongoing psychiatric treatment to a variety of populations, including geriatric, hearing impaired, behavior management, and others. In keeping with the recovery-based model

of care, the Hospital has established an environment of care that allows patients to leave their units during the day and receive the majority of treatment at a "treatment mall." This concept promotes community reintegration and assures that all patients are involved in active treatment. The treatment mall provides specialized programming for Geriatrics, Co-occurring illness, Cognitive Remediation, Behavior Management, Hearing Impaired, Psychosocial Rehabilitation, and Acute Care.

During fiscal year 2002, Saint Elizabeths Hospital (SEH) staff continued to make programmatic changes in support of the new mental health delivery system. The focus was on increased therapeutic activities and less reliance on the hospital services. All hospital staff were involved in the creation of a treatment mall that affords "off unit" activities for nearly all patients in the Continuing Care Program of the hospital, and for most of those patients in the Acute Care Programs. Expansion of therapeutic activities in the Forensic Program was also addressed during the year, with positive results in all three components of the hospital.

While the hospital had a small treatment mall in operation in the Continuing Care program during fiscal year 2001 (50-60 patients), major efforts to enhance programming were initiated by the new Chief Executive Officer, resulting in the development of a treatment mall that serves more than 200 patients in both the Acute and Continuing Care programs, and provides more than 4,000 hours of active group treatment each month. The focus of these groups is to promote recovery and have patients become less reliant on hospital services. Specialized programming for Geriatrics, Dual Diagnoses, Cognitive Remediation, Behavior Management, Hearing Impaired, Psychosocial Rehabilitation, and acute needs are all provided. Major changes in the way clinical and support services are delivered have resulted in improved care to patients. During the year, SEH received an unconditional review from the Centers for Medicare and Medicaid Services (CMS).

The SEH continues to have a forensic community service component as part of the overall Forensic Program. The goal of the program is to promote pretrial release of appropriate defendants to community-based case management and treatment thereby ensuring the defendant's return to court and providing for public safety. The clinical and administrative staff of the Forensic Inpatient Services Division collaborated with the Public Defender Service and identified inpatient pre-trial defendant/consumers who were scheduled to return to court and might be appropriate for inclusion in the program.

B. Government Sector Issues and Concerns

The District of Columbia was one of the jurisdictions directly affected by the terrorist attack on the United States in September 2001. The DMH, along with other agencies and organizations recognized that there were service gaps in responding to the mental health needs of individuals and groups in the aftermath of such an attack.

The DMH developed and implemented several projects and supported others to address these gaps. The projects include the following:

- Mayor's Domestic Preparedness Task Force Mental Health Subcommittee – this work group of public and private providers provided input into District wide planning related to crisis/emergency preparedness and served as a forum for resource sharing;
- September 11 Response Network – a group of private providers and DMH worked collaboratively to provide information and services to consumers;
- Terrorism Related Mental Health Needs Assessment Grant – the Substance Abuse and Mental Health Services Administration (SAMSHA) awarded this grant to conduct short-term assessments of mental health services and support needs;
- Terrorism related Disaster Relief Grant – SAMHSA also awarded the District this grant to fund several projects the include among others the development of the Office on Disaster Response, community crisis response training, a special population initiative and provider education;
- Terrorism related Disaster Relief Grant Supplemental Funds – the funds from this SAMSHA grant are directed to initiatives to better respond to the co-occurring disorders of mental illness and substance abuse, which have increased in number since September 11, 2001;
- FEMA Immediate Services Program Grant – FEMA and its collaborating agency, the Center for Mental Health Services awarded DMH a grant to establish a community education and outreach project that focused on terrorism including anthrax exposure (Project DC).
- Emergency Preparedness Funds – DMH has received a portion of funds for emergency preparedness that will be used for projects that address emergency mental health management, community outreach, broadcast media, training, partnerships with the academic medical centers and communications;
- Metropolitan Washington Mental Health Community Response Coalition – the DMH served as a member of this Coalition formed to respond to the Pentagon attacks and other terrorist activities.

C. Non-Government Sector

The non-government sector in the District consists of HMOs/MCO Behavioral Health Plans, private hospitals, private agencies including several free-standing mental health clinics, and a host of private practitioners. Many of the consumers that are referred to private facilities for mental health services originate from the D.C. Department of Justice and hospital emergency departments in the area.

To facilitate the integration of the private sector into the District's mental health system, the DMH established the Mental Health Rehabilitation Services program to deliver Medicaid Core Services. The providers of these services are now certified and/or licensed by the DMH (see Table 1 for a listing of providers). Additionally, the DMH has the authority to monitor and investigate unusual incidents at the Core Services provider's facilities.

Psychiatric Institute of Washington

The Psychiatric Institute of Washington (PIW) is a short-term, 104 beds, acute care hospital that provides comprehensive behavioral healthcare (mental health and substance abuse) for children,

adolescents, adults, and senior adults suffering from emotional and addictive illnesses. PIW offers inpatient, outpatient, hospitalization, 23-hour crisis observation, as well as, specialized treatment programs for chemical dependency. In addition, PIW has a Clinical Assessment Center. PIW has been providing services to the Washington area since 1967.

According to PIW staff and PIW literature, the following services are available:

- Clinical assessment Center;
- Children's Services Program;
- Adolescent Treatment Services;
- Adolescent Diagnostic Services;
- Adult Services;
- Partial Hospitalization Programs;
- Chemical Dependency Services;
- The Passage Program;
- The Center Post-Traumatic & dissociate Disorders Program; and,
- Gay, Lesbian, Bisexual and Transgender Program.

PIW's clinical assessment center, which is open to the public on a 24-hour basis, performed approximately 5,000 assessments in 2002. This service has served a critical function in maintaining the accessibility of mental health services to District adults and youth.

Riverside Hospital

Riverside Hospital is 150-bed psychiatric hospital, residential treatment center and behavioral health care system located on three acres of land in Northwest Washington, D.C. Riverside Hospital provides a full continuum of Diagnostic, Psychiatric, Dual Diagnosis, Substance Abuse, Psychoeducational, and therapeutic treatment services to children, adolescents, young adults and their families. Riverside Hospital and Riverside Residential Treatment Center were founded for the specific purpose of providing exceptionally challenged children, adolescents and young adults with treatment programs that would be solution-oriented, culturally sensitive and comprehensive in scope and vision.

Riverside's Intake/Assessment Center is open to the public on a 24-hour, seven days per week basis.

Services provided by Riverside Hospital include:

- Psychiatric, Psychological, and Psychoeducational assessments and Treatment Services;
- Neuropsychiatric Services;
- Individual, Group and Special Topic Therapy;
- Family Therapy;
- Parenting Skills/Education;
- Year-Round Special Education School (certified by the Middle States Association);
- Chemical Dependency Treatment and Education;

- Expressive Therapies;
- Vocational Education;
- Life Skills Training;
- Outpatient Services;
- Discharge and Transitional Services; and,
- Cultural Enrichment Programs.

Riverside Hospital, since opening in 1995, has treated over 2,500 children and adolescents. Since 95% of the patient population is Medicaid, Riverside serves a patient population within the District that is at poverty level or what is commonly referred to as the "working poor" and one that is in urgent need of psychiatric care.

Patients from Riverside Hospital are referred from every quadrant of the District with 25% of referrals coming directly from family members.

In 2002, Riverside's Admissions team assessed over 2000 children youth and young adults.

D. Issues and Concerns of Non-Governmental Sector

- Improved Coordination of Regulatory Activities
- Additional behavioral health providers (psychiatrists, psychiatric nurses)
- Disparity in reimbursement
- Medicaid Exclusion of Certain Services

III. SUMMARY RESOURCE INVENTORY AND HISTORICAL UTILIZATION OF SERVICES

The Current Mental Health System in the Community

The seriously mentally ill citizens in the District of Columbia receive publicly funded mental health services through the CSAs, Specialty Agencies and Sub-Providers (to CSAs). The largest of the 14 certified CSAs is the District funded CSA, the DCCSA. It has service locations in several areas of the city including the Northwest, Northeast and Southeast quadrants, and on the grounds of Saint Elizabeths Hospital. The other 13 private CSAs are geographically located throughout the District of Columbia. A number of the private CSAs also have multiple service sites.

In addition to the CSAs, entry into the adult system of care now utilizes a "no wrong door approach." Clients may be enrolled through any one of the CSAs they choose to receive services. Additionally, individuals may call the 24 hour Access Help Line at" 1-888-7- We Help" to be enrolled in DMH services or be connected to other systems and services as appropriate. An appointment is given to the consumer based on the DMH MHRS standards for routine, urgent and emergent care. Consumers who present in crisis, may also enter the DMH system of services through the DCCSA operated Comprehensive Psychiatric Emergency Program (CPEP).

Persons entering from any of these portals of entry are evaluated by the Access Care Coordination staff to determine an appropriate level of care and services are assigned to meet the client's choice and needs.

The consumer is enrolled in the CSA of his/her choice, and then stabilized, assessed and connected to the least restrictive care alternative. If the person is unable to choose a CSA one is assigned. This may be changed when the consumer can make an informed decision as to their choice of a clinical home.

The CPEP has two holding beds for individuals who are discharged or awaiting disposition, and three restraining beds. In addition, as a result of an evaluation and time study of beds being used for crisis resolution new clinically enhanced staffing patterns and practice guidelines were developed, new per diem rates were established, and new contracts were developed using the DMH Human Care Agreement fee-for-service approach. An eight-bed Step Down service has been contracted to one of the District's private non-profit providers. The DMH is in the process of developing eight crisis beds in the community where consumers may be treated for crisis resolution. Continuing stay review and authorization is required every 7 days through the Access Help Line.

The DMH contracts for or provides a comprehensive system of nine services that are both Medicaid and local funded, based on a consumer's eligibility. MHRS service types include diagnostic assessment, medication/somatic treatment; counseling and psychotherapy, crisis emergency services, day services, intensive day treatment, community-based intervention, community support services, ACT services. There are another 10 non Medicaid reimbursed adult services provided by multiple providers as follows: Residential Crisis Services, Step Down/Transitional Beds, 24- Hour Residential Services (transitional), 24-hour Supervised Beds, Supportive Housing/ Supervised Apartments, Consumer Advocacy, Peer Support Services, Jail Diversion/Outpatient Forensic Services, Supportive Employment and Socialization Services.

In order to ensure continuity of care, DMH has implemented a new continuity of care policy. Each Core Services Agency is immediately notified of admissions of its enrolled consumers and new consumers enrolled with it through their 24- hour on-call process. The assigned community clinical manager is required to meet with the consumer and begin collaboration with the hospital treatment team within 48 hours. Within five days a treatment plan is developed involving the consumer, CSA, hospital treatment team and any significant others the consumer chooses to involve in their care. The CSA clinical manager will meet with the consumer at least weekly while in the hospital.

The Continuing Care Program of the hospital provides treatment to individuals who have been at Saint Elizabeths Hospital for an extended period of time, and who are awaiting discharge to appropriate community programs. There was a realignment of programs within this component of the hospital during fiscal year 2002 as consumer needs were assessed and efforts made to create a less restrictive environment. An Unlocked Wards program provides community-focused activities for those persons who are imminently ready for community placement but are primarily awaiting appropriate housing or financial supports. A Behavior Management program

addresses specific needs of individuals with impulse control difficulties and a history of inappropriate behavior.

Elderly consumers are treated on a separate unit to assure safety and age-appropriate interventions, and those individuals with medical problems in addition to their mental illness are treated on a unit where the medical needs are emphasized. The Continuing Care program also has a unit that provides inpatient care to hearing impaired adults. This unit works collaboratively with the DCCSA that administers a large outpatient program for the hearing impaired.

Specialized Services

Specialized Services for the Elderly

A number a specialized services are provided such as Geriatric Services where age appropriate case management and a variety of specialized supportive, outreach, medical services and activities are provided for older adults. Additional specialized community services exist for persons who are deaf and hearing-impaired, have co- occurring mental health and substance abuse disorders; and are homeless and mentally ill.

The DMH older adult consumers who are outpatients receive assessment, psychiatric treatment, community support services, ACT, outreach, day treatment, medication, referral, and other services necessary for living in the community both through specialized geriatric programs within two of the three DCCSA service centers and the services teams of the other CSAs. A Geriatric Services Branch in each center provides comprehensive, continuous care to meet the needs of older adult consumers. The consumers are supported through community support services in their own homes or may be placed in Community Residential Facilities (CRFs), nursing homes, or with their immediate guardian.

Forensic Services

The forensic mental health consumer population presents with unique challenges and needs that have given rise to a number of first-time collaborations with various criminal justice agencies in the effort to ensure access and service linkage.

The Forensic Services Program provides a full range of mental health services to pre and post-trial populations. The courts review and control access to the Forensic Program, and evaluations and treatment are for adults who are referred or committed by the criminal courts. Services to forensic inpatients include evaluations of competency to stand trial and criminal responsibility; treatment of defendants in need of hospitalization to restore them to competency before trial, treatment of those adjudicated not competent and unlikely to regain competency in the foreseeable future while awaiting civil commitment; treatment of consumers found Not Guilty By Reason of Insanity (NGBRI) and committed for inpatient treatment until released by the court; treatment of defendants and sentenced prisoners in the custody of the D.C. Department of Corrections who require treatment in a hospital setting because of a deterioration of their mental health.

The Legal Services Bureau provides pre-trial, pre-sentencing, and other evaluation and assessment services to the criminal courts for individuals residing in the community or at correctional facilities. The Forensic Inpatient Program has 243 beds, as well as an outpatient branch for those individuals that have been acquitted due to insanity and are on conditional release in the community.

Co-Occurring Disorders Services

Some of the CSAs have specialized services for persons with co-occurring mental illness and substance abuse disorders. These programs provide specialized group therapy, relapse prevention and Alcoholics Anonymous/Narcotics Anonymous services.

During fiscal year 2002 DMH continued its efforts to improve the way it provides services to persons with co-occurring mental and substance abuse disorders and to better integrate with other systems that serves this group of individuals, i.e. District's Addiction Prevention and Recovery Administration (APRA), the Department of Corrections and Federal prison treatment system.

The DMH has been meeting regularly with APRA leadership to integrate its services both at the system and service levels. One current focus is on revising the current Memorandum of Understanding. APRA intends to continue to purchase over $600,000 of co-occurring treatment and support services from the DMH. The newly developed plan for these services is to fully move them from the grounds of Saint Elizabeths Hospital and integrate them across the APRA and DMH service system. Plans to co-locate and integrate these staff in the APRA intake and assessment unit, APRA treatment sites, and on the DCCSA Community Support and ACT teams are being finalized.

The DMH and APRA are also moving to adopting a common system's model of co-occurring disorder services. The DMH has designated an outside organization to perform consultation and training in adopting the Comprehensive, Continuous, Integrated, System of Co-occurring Services (CCISC) across the agencies and Departments in the District that serve this population. Leadership and treatment staff from both APRA and DMH attended the SAMHSA conference on co-occurring disorders in August 2002. A joint core leadership group has been formed to develop a detailed implementation plan. This outside organization will provide technical assistance, resources and training to assist with developing staff competencies and program capability to serve person's with co-occurring disorders across all service types in DMH, APRA and the forensic services community. APRA leadership has already indicated a willingness to jointly adopt this model and commit some of its own resources to implementing it in their system of care.

Multicultural Services

The Multicultural Services Division (MSD) of the DCCSA provides a range of services Co-occurring Mentally Ill/Substance Abuse (MI/SA) services (intake and referral, outpatient and case management, day treatment, medical and outreach services) to persons from linguistically, culturally/ethnically diverse populations. Additionally, as part of its ongoing effort to provide culturally competent services to our consumers, MSD has updated its Language Bank to increase

the number of volunteers, and expanded the number of languages covered to ensure that information is accurate and up-to-date. The Language Bank includes a list of individuals who are available to provide interpretation or translation services on a volunteer basis.

Pharmaceutical Services

The DMH has implemented the DCMAP (District of Columbia Medication Access Project) which provides algorithms (guidelines and procedures) for psychiatrists treating consumers with schizophrenia. This program is modeled after the highly successful TMAP (Texas Medication Algorithm Program), developed by the Texas Department of Mental Health and Retardation in collaboration with Texas universities. Algorithms will help facilitate clinical decision-making by providing physicians with current information on the newest psychotropic medications and research data, as well as specific treatment sequences with tactical recommendations. It is expected that the employment of such treatment guidelines to treat the severely and persistently mentally ill population may bring about a decrease in the use of crisis/hospital services and the number of clinical visits. This will also increase overall efficiency of consumer care while providing accountability for scarce resources. DCMAP has been implemented throughout the District system of care and Saint Elizabeths Hospital. Easy to understand, consumer educational materials have been developed in English and Spanish. Algorithms for schizophrenia and depression have been distributed.

Rehabilitation and Support Services

The DMH provides an array of rehabilitative and support services directed toward enabling seriously mentally ill adults to live in the least restrictive community setting, as independently and self sufficiently as possible. Large-scale training has been provided to staff to shift to a strengths-based recovery model of treatment and rehabilitative services. Working with consumers on their areas of choice and reaching mutually agreeable goals is seen as paramount in receiving good outcomes. The IRP assessment and treatment planning process requires that the life domains of individuals such as the need for housing, meaningful activities such as work or education, housing, interpersonal relationships, socialization, medical/health needs and mental health services and supports are assessed. Rehabilitative services are provided directly by DMH staff and through contractual arrangement with private vendors.

Supportive Competitive Employment

The DMH provides an array of individualized support services directed towards recovery and full community participation. In fiscal year 2001, a major initiative was begun and is continuing to redirect resources from traditional sheltered work models, including the Work Adjustment Training Program at Saint Elizabeths Hospital, and to expand supported competitive employment opportunities in local businesses.

Supported competitive employment is based on very clear principles:

- Integrated rather than segregated work sites;
- Direct placement in jobs without a pre-employment training period;
- Tailoring of job requirements to the consumer's strengths;

- Individualized, time unlimited supports; and
- Wages at market rate or above rather than a training wage.

The DMH is committed to the expansion of supported competitive employment opportunities for individuals with a serious mental illness. Significant work is underway to redesign existing employment services so they are consistent with the principles outlined.

The DMH has established partnerships with the Virginia Commonwealth University's Rehabilitation, Research and Training Center for Workplace Supports (VCU-RRTC), and with Dartmouth Psychiatric Research Center and the Johnson and Johnson Foundation. Some of the accomplishments include: development and posting of the VCU-RRTC six lesson web-based course on evidence-based supported employment for individuals with mental illness; selection of three demonstration sites to be funded by the Johnson and Johnson—Dartmouth Community Mental Health Program, and the provision of training and technical assistance to these sites related to the conversion of sheltered work into supported competitive employment in integrated settings; and the transfer of the DMH funded Work Adjustment Training Program (WATP) formerly located at Saint Elizabeths Hospital to the D.C. Community Services Agency.

Housing and Residential Services

Housing meets a basic human need and is necessary for the recovery of individuals and families experiencing mental illness. Supported housing appears to be the housing choice for many consumers. There is a growing preference among DMH consumers to choose their own housing, to live with whom they wish, and to receive the supports they want and need. These are compelling reasons for major changes in the way DMH provides housing and services. Supported housing is a necessary component of the community-based, recovery-focused mental health system.

After an intensive planning initiative including consumers, family advocates, providers housing developers and other stakeholders, DMH initiated a plan to increase community-housing capacity over a three-year period. Consensus was reached on the implementation of the supported housing approach that is drastically changing the way housing and services are provided. A major systems change initiative was launched. The Department is beginning its second year of this three-year plan. Major system changes are continuing to occur with the development of supported housing. Conversion to this model has been somewhat slower than hoped in part because of the length of time that it has taken to implement the MHRS system necessary to fund the wraparound supports and to develop financing mechanisms other than private financing to lower the rents of the newly developed housing units to be within the reach of the income of DMH consumers. The implementation of the MHRS service taxonomy and fee-for-service system now pays for up to 24- hour wraparound supports that can be provided according to their Individualized Recovery Plan in the consumers own home or building. A similar group of housing stakeholders is being convened to review and revise the goals of the current DMH Housing Plan.

The shift from a focus on a traditional supervised residential service continuum to a priority on supported housing is an extraordinary systems change initiative in the District of Columbia. It

will require an analysis (internal and external) of the opportunities and barriers that impact the further expansion and development of supported housing. There will continue to be a need for clinically focused supervised community residential settings, in addition to a variety of "best practice" housing models utilizing the supported housing approach.

Consumer Choice and Housing

In keeping with the DMH principle that consumers are entitled to choice in where and what services they receive in the District adult mental health system, a new emergency housing rule is now being drafted that allows DMH consumers to choose their type of housing such as whether they want to live in their own apartment or with others. It also assures that Community Support workers perform thorough housing inspections of all DMH supported housing at least quarterly.

Currently, a large portion of DMH housing resources are dedicated to a system of 24-hour supervised group homes, i.e. community residential facilities (CRFs). As of August 2002, the total housing capacity for these CRFs was 1871. Approximately 60 percent of the total adult services budget for contracted services continues to be devoted to 24-hour supervised housing. The DMH is committed to providing the leadership to work with consumer and family groups, public and private policy makers, providers, the advocacy community and housing developers and landlords, to change an entrenched culture that believes that consumers cannot live independently and hold their own leases like other tenants in the District of Columbia. DMH will be fully involved with these constituency groups in the development and implementation of strategies to overcome the regulatory, financial, attitudinal and other barriers to the expansion of supportive housing.

The DMH system commitment of resources will be for the production of new permanent, affordable supported housing to serve the majority of consumers in need and to continue to increase Bridge Rental Subsidy Supports, including the use of some Mental Health Block Grant (MHBG) funds to support consumers in independent housing settings, until they receive permanent housing subsidies or are able to earn sufficient income to live and pay rents on their own.

Educational Services

Educational services are available through DMH. The DMH has a limited program which includes remedial educational instruction, uses materials and techniques specifically designed to meet the individual instructional needs of consumers with mental illness who have deficiencies in basic educational areas (e.g. reading, writing and arithmetic). There is also a specially designed group for educational instruction to meet the needs of the individual consumers with handicapping conditions. The consumer's academic needs and goals are based on an assessment of developmental areas including social, physical and educational achievement and learning characteristics. This service assists consumers in locating a full range of educational opportunities, from basic literacy through the General Equivalency Diploma and college.

Crisis Stabilization

The DMH has expanded crisis/emergency services. Each Core Services Agency must have an on-call system for crises and provide a crisis plan for each consumer in their Individual Recovery

Plan (IRP) or Individual Service Specific Plan (ISSP). There are two certified Crisis/Emergency Providers (CEPs) who can be accessed through direct referral. These agencies, the District of Columbia Community Services Agency and Hillcrest Children's Center, provide mobile and on-site crisis assessment and stabilization services 24 hours a day, seven days a week and serve as a central point of entry into DMH for non-DMH consumers experiencing crises, especially those requiring hospitalization. The Access Help Line also receives referrals for crisis services.

Crisis beds are currently available for up to 24 consumers who can be stabilized in a community setting for a period not to exceed thirty days. The scope of work for these facilities was revised to increase clinical support services and provide a step-down function so that they would provide an increased hospital diversion option. Consumers are referred through a certified Core Services Agency (CSA) or a certified Assertive Community Treatment (ACT) provider. Plans for the next fiscal year include continued development of step-down units and transitional settings to reduce the need for prolonged use of crisis beds due to the possible unavailability of appropriate housing.

Case Management Services

The major purpose of the DMH case management system is to ensure that the necessary and agreed upon treatment and supports are provided and are adjusted continuously to meet the changing needs and choices of the consumer. Therefore, a comprehensive plan of care must be developed before linking consumers to appropriate services and programs.

The DMH strives to create an effective, welcoming, community support/case management system that is based on the consumer strengths and choices, promotes recovery through the attainment of individualized goals to help the consumer develop the skills to live the best possible quality of life, and provides aggressive outreach to maintain consumers in the community. The DMH case management is provided to consumers in a number of ways by both DMH practitioners and private providers and is based on the individual consumer's treatment needs as determined through the individualized recovery planning process where attainable, mutually agreeable goals and objectives are developed. Each consumer is assigned a clinical manager (case manager) and qualified practitioner to coordinate consumer care, often across multiple provider agencies and to provide rehabilitation services, treatment and supports. At a minimum of every 90 days the consumer's clinical manager is responsible for assessing with the consumer each of the consumer's major life domains and assess which areas of need are to be worked on for the next period of time.

Mental Health Services for Children

Widespread psychosocial and educational problems affect the ability of many students to be successful in the classroom. Early detection of and effective school-based programs to address the most common problems can make a major difference in a student's overall learning and performance. Examples of these problems are: learning problems; language difficulties; attention problems; school adjustment and other life transition problems; attendance problems and dropout; social, interpersonal, and familial problems; conduct and behavior problems;

delinquency and gang-related problems; anxiety problems; sexual and physical abuse; neglect; substance abuse; psychological reactions to physical stature and inappropriate sexual activity.

In 2000, there were 9264 cases of children under the age of 18 years of age diagnosed with Serious Emotional Disturbance (See **Table 2** for a breakdown of this age group cohort). This represented 7.46 percent of children in that age group. The exact number of children and youth who are homeless is more difficult to ascertain, however, it is known that homelessness continues to affect District of Columbia citizens at a rate almost twice that of other large urban areas. According to data provided by the National Resource Center on Homelessness and Mental Illness an estimated 842,000 adults and children nationally are homeless in a given week. Eleven percent (11%) of this population consists of parents with children, 84% of whom are single women. African Americans are over represented in this population at 40% compared to 11% in the general population. Homelessness is largely an urban phenomenon with seventy-one percent (71%) of the target population occurring in central cities. Homeless individuals also share the following characteristics: 25% were physically or sexually abused as children, 27% were in foster care or institutions as children, 21% were homeless as children, and 54% were incarcerated at some point of their lives.

Table 2. Estimates of Number of Cases of Serious Emotional Disturbance (SED) in Children and Youth by Age, Gender, Ethnicity & Poverty, Washington, DC - 2000

	Total Population			**Households less than 100% Poverty**		
YOUTH	**CASES**	**POP.**	**PERCENT**	**CASES**	**POP.**	**PERCENT**
Age						
0-6	3663	48179	7.60	1229	12289	10.00
7-12	2851	38431	7.42	867	8667	10.00
13-17	2749	37647	7.30	598	5979	10.00
TOTAL	9263	124257				
Gender						
Male	4791	63927	7.49	1340	13404	10.00
Female	4472	60330	7.41	1353	13532	10.00
TOTAL	9263	124257				
Ethnicity						
White	1663	25933	6.41	112	1116	10.00
Black	6505	83929	7.75	2271	22711	10.00
Asian	118	1634	7.21	20	198	10.00
Native American	19	171	11.19	3	29	10.00
Hispanic	958	12590	7.61	288	2881	10.00
TOTAL	9263	124257				
Poverty Level						
Below	3020	29236	10.33	2694	26936	10.00

	Total Population			Households less than 100% Poverty		
100%						
100%-199%	2142	26726	8.02	0	26726	0
200%+	4101	68295	6.00	0	68295	0
TOTAL	9263	124257				

These data reflect the fact that children and youth who are homeless and raised in families in extreme poverty often are at serious risk for exposure to life circumstances that are known to result in serious emotional disturbance. These serious mental health problems impact on their ability to function successfully in the home, the school, and the community often resulting in further social dislocations in out-of-home settings that include the juvenile justice system.

The DMH Child and Youth Services Division will target the needs of children and youth who are homeless. The implementation of the HUB concept will greatly enhance DMH's efforts to reach all consumers in need of services. The reorganizing of service delivery will also serve as a means of providing appropriate intensive services to the children, youth and their families who are homeless. The DMH will continue its collaboration with the Community Partnership for the Prevention of Homelessness in providing housing and other critical services to District consumers.

The DMH efforts include aggressive outreach to children, youth and their families by engendering trust and demonstrating commitment to assist and provide services. The utilization of a strength-based approach to identifying the individualized needs of children and youth who are homeless will aid in dispelling some of the mistrust that oftentimes serves as a barrier to service delivery. Some of the difficulties that children and youth present may be characterized by periodic episodes of acting out or other disturbing behaviors, strained relationships with their peers, lack of self confidence, and inability to concentrate that leads to an inability to perform academically. The District's children and youth need aggressive outreach to engage them in services and to continue to help them receive much needed services.

The DMH will have the key leadership role in the design and development of an overall "systems of care" model. These systems of care will address the challenges faced by children and youth experiencing all forms of mental illness and/or emotional problems, which often must deal with multiple and often unconnected service systems. Implementing this model will require the DMH to take the lead in developing alternative approaches to the planning, funding and delivery of services. These approaches stress cross-agency partnerships; a shared responsibility for ultimate outcomes; mobile/onsite responses by mental health professionals; a shared philosophy of consumer-driven services and family-driven supports; and the mixing and matching of funding streams to support an overall services plan and management strategies, including streamlined, integrated service planning that meets the needs of children and youth and their families in a variety of settings, must be implemented across all systems of care.

Child services address more specifically the mental health component of the overall system of care. This component commits to the reliable and effective provision of mental health and related services to children, youth and their families, no matter how complex their needs, with maximum consideration given to child, youth and family choice in treatment. A key to achieving this goal is organizing the system in a manner that assures that each child or youth has his/her own "clinical home", an entity responsible for and accountable to that child or youth, for the full array of their service and support needs on a continuous basis, regardless of the child or youth's legal, clinical or physical status.

The MHRS allows children and youth access to the following services funded with both Medicaid and local dollars:

- Diagnostic/assessment;
- Medication and somatic treatment;
- Counseling;
- Community support;
- Crisis/emergency;
- Community-based intervention (focused on in-home supports);
- Intensive day treatment;
- Day services (rehabilitation); and
- Assertive community treatment.

In addition, the DMH will also make available other services such as:

- Adjunctive child therapy (e.g., psychodrama, art therapy, music therapy);
- Acute inpatient psychiatric services;
- Residential services;
- Psycho-educational services; and
- Peer and family supports.

The DMH in its efforts to have a stronger and better integrated access to crisis services will utilize the "Hub" concept to provide a range of crisis services options available to meet the needs children and youth in varying levels of crisis. A key element of the Hub model is a 24-hour, 7-days-a-week telephone hotline, information and referral, dispatch and triage center, operated by the DMH. This center will be located at the headquarters of the DMH. Specifically, it will:

- Provide initial telephonic professional assessment, crisis intervention and triage for persons presenting for service;
- Dispatch crisis mobile teams as appropriate after initial and immediate assessment;
- Coordinate access and link person to out-of-home crisis stabilization services; provide crisis back-up telephone, triage and dispatch support to site-based psychiatric crisis-emergency and crisis stabilization providers, as well as other health and safety systems (e.g. Metropolitan Police Department, Child and Family Services Agency, Youth Services Administration, District of Columbia Public Schools, etc.);
- Connect children and youth to services;

- Facilitate communication for the entire system through the DMH and private mental health and other health and human services providers, and other information regarding benefits, legal requirements, eligibility as requested by callers; and
- Provide a trained volunteer-based telephone line for persons needing such contact and for telephone wellness checks.

In addition to the Hub services, there will be the Access Crisis Response System that will include mobile crisis teams, site-based psychiatric emergency services and crisis stabilization services. Separate mobile crisis teams will be available 24-hours a day, 7-days a week for children and youth. All teams will be trained to provide back-up coverage for persons of all ages to assure adequate coverage in the event that demand exceeds available resources. Site-based psychiatric emergency services will also be available 24-hours a day, 7-days a week. Crisis stabilization services may be provided in the home or outside of the home. The MHRS supports increased in-home services capacity, which is described as "Community-Based Intervention" for children and youth. These interventions are developed with the child, youth and their family. Out-of-home crisis stabilization is provided in respite locations or emergency therapeutic care programs for children and youth.

The DMH operates a single public CSA (DCCSA) and will contract with other agencies from the provider network to provide the full range of services to children, youth and their families. The DCCSA integrates the DMH-operated Multicultural Services and Assertive Community Treatment (ACT) Teams, so as to create a stronger focus on families throughout the service system. While specialized and separate services for children and youth will be maintained, duplicative infrastructure will be eliminated. Some service sites serve as models for providing both adult and children/youth services. Hence, the public CSA (DCCSA) will comprise the previously known Community Services Administration (serving adults) and the Child and Youth Services Administration (serving children and youth).

The charge of the DMH, along with the District of Columbia's Sub-Council of the District's Inter-governmental Youth Investment Collaborative, will be to facilitate the development of comprehensive, individualized and well-coordinated plans of care for all youth in need of being diverted or returned from out-of-home placements or residential facilities. Best practices suggest that intensive case management, housing, employment, education, family support and other critical life supports are some of the essentials to successfully diverting or returning children and youth to their communities. The Sub-Council with its representation from all critical child-serving agencies and supportive services will ensure a seamless "wraparound" services approach, which stresses that programs and services must be tailored to meet the specific needs of each child/youth is a routine practice.

The children's mental health system provides culturally competent family and consumer-care, and emphasizes early intervention and outreach to children and youth. The community-based components provide children and their families a variety of non-acute outpatient therapeutic services. Intensive services, including diagnostic evaluations, crisis intervention and assessment for hospitalization, outpatient therapy, medication management, case management, psycho-educational programs, community support services, and community-based interventions are now provided through Child and Youth Community Support Services, Child and Youth Community-

Based Intervention Services, Child and Youth Psycho-educational Services, and Child and Youth Forensic Services.

The Acute Inpatient Services Bureau serving children and adolescents was closed in May 2001. Now children and youth requiring acute inpatient psychiatric hospitalization are being served in the Washington, D.C. community by three private providers: Children's National Medical Center, Psychiatric Institute of Washington, and Riverside Hospital. In a related organizational consolidation, in August of 2001 the Adolescent Day Treatment Program was merged into the Jackie Robinson Adolescent Psycho-Educational Program. This effort was undertaken to strengthen the DCCSA capability to address the expanding need in the city for psycho-educational services to the adolescent population.

Some of the consumers who continue to be served include:

- Members of the public receiving crisis outreach services;
- Family members and caretakers of children/youth receiving mental health education, support services and family therapy;
- Potential consumers of psycho-educational services who are assessed but not accepted into the programs;
- All detained youth receiving services at Oak Hill Youth Center (juvenile detention); and
- All children/youth and caretakers assessed for D.C. Superior Court at Youth Forensic Services.

Based on recorded information available in the MIS for registered consumers:

- 66.1% of consumers were male and 33.9% were female;
- Approximately 89.3% were Black, 7% Hispanic; and White and Asian combined, 1%;
- Less than 1% were 0-5 years, 52% 6-12 years, 30% 13-17 years, less than 1% 18-21 years, and less than 1% 22 years and above.

Consumers 18 years or older may have been clients who received CYS services prior to their 18th birthday and subsequently transitioned into adult programs. They may also have been family members of infants in the Parent-Infant Development Program, who are registered along with the infant.

Child and Youth Community-Based Intervention (CBI) Services - Formerly called Child and Adolescent Psychiatric Emergency Services (CAPES), this program provides emergency and walk-in assessment and evaluates the need for hospitalization. In addition, it responds to psychosocial and psychiatric crises that most often occur as a result of children being exposed to violence in their communities. CBI works with children to diminish the impact of violence by providing on-site crisis intervention along with consultation, education, and training on child/youth mental health issues. Referral to and information on CYS services has also been provided in schools to children and school staff. The DMH will be partnering with Children's National Medical Center at the location where all future child and youth psychiatric emergencies will be served.

Other outreach services provided by outpatient clinics include in-home crisis intervention, community-based violence prevention, referral and information services, and therapy for court-involved youth.

Public School Mental Health Expansion Project - This school-based mental health program is funded through a grant received by partnering with the Public Charter Schools entitled Safe Schools/Healthy Students Initiative which allows the CYS to provide child and family centered school-based mental health services in identified public and charter schools within the District of Columbia. Prevention, early intervention and treatment services are provided. Currently, the project operates in nine public charter schools and 14 DC Public Schools.

Child and Youth Community Support Programs- The former Northwest Family Center (NWFC) and Child and Family Therapy Center (CFTC) are part of the current CYS Community Support Programs. Services are provided for children/adolescents and their families, ages 5 through 17 years of age. The services include crisis intervention, case management, intake, screening, assessment, evaluation, medication management, treatment planning, referral services, and individual, family and group psychotherapy. These services are offered in the clinics and in various D.C. Public Schools.

Also included in this cluster is the former Parent-Infant Development Program. While specific services for children and adolescents are located within several CYS outpatient programs, services for infants (birth to 5 years of age and expectant parents) are provided through the Parent and Infant Development Program (PIDP). The services are targeted to expectant mothers, family members, and caretakers with mental illness and substance abuse histories. Infants with emotional and developmental problems and those infants who have been sexually and/or physically abused receive evaluation and early intervention services.

Child and Youth Psycho-Educational Services - Children ages 6-12 years old, with SED, participate in full-time psycho-educational programs (structured therapeutic milieus) at the Rose School (RS) and the Paul Robeson School (PRS). Intensive case management, social work and psychological services, individualized education services, psychiatric services and adjunctive therapies are provided. Adolescents, ages 13 to 17 years old, receive psycho-educational services within a therapeutic setting at the Jackie Robinson Center (JRC). Intensive case management, individualized education and multidisciplinary clinical services are delivered. Adjunctive therapies (art, music, and psychodrama) are provided on site. In fiscal year 2000, the Adolescent Day treatment program was merged with the JRC psycho-educational program.

Also included in this cluster are the Therapeutic Nursery programs. At present three therapeutic nurseries, located within District of Columbia Pubic Schools serve children 3-6 years old who may have an emotional disturbance or are developmentally delayed.

Residential Care - The eligibility, placement, case management and facility monitoring functions of the former Residential Placement Unit (RPU) are being transitioned into the appropriate offices within the Mental Health Authority and the CSAs (i.e., Accountability, Care Coordination and Multi-Agency Planning Teams, DCCSA, etc.).

Most residential treatment facilities are located in other states. One public residential facility for children ages 6-12 operates within the District. This facility is the Hurt Home, which is funded by CYS and administered through a contract with the Devereux Foundation. Riverside Hospital has a (72 bed) Residential Treatment facility (mental health and substance abuse) for children and adolescents.

Child and Youth Forensic Services -Youth Forensic Services (YFS) provides psychiatric screening of court-involved children and youth to determine their competency or need for hospitalization. Outpatient court-ordered psychiatric and psychological evaluations are also conducted for abused and neglected children. Oak Hill Youth Center (OHYC), a District of Columbia youth detention facility that is administered by the Youth Services Administration (YSA) currently provides mental health services for detained youth. YSA detainees and committed youth receive mental health services, which include psychiatric and psychological screening and evaluations along with multi-modal therapies.

The DMH continues to work with the Juvenile Justice Advisory Group (JJAG) to implement an initiative called the Alternative Pathways Project. This is an initiative that will be funded with a grant from JJAG, wherein all children and youth with mental health needs who are on a path into the juvenile justice system will be appropriately diverted for treatment rather than processed for detention or commitment. In a related initiative the DMH is partnering with D.C. Superior Court Social Services agency (Probation) to redesign the front-end intake process so that appropriate mental health staff are available to provide input in the early screening of cases entering the juvenile justice system. This staff will also be available to appropriately and timely address emergency mental health screening and evaluation needs of the Judiciary. These efforts are also being coordinated with the Children Inspired Now Gain Strength Project (D.C. CINGS Project).

Case Management- All CYS consumers receive case management services to coordinate and facilitate professional services. Case managers:

- Participate in the assessment of the child and family;
- Serve as an advocate and helper, and act as a liaison and broker for services on behalf of the child and family in providing access to needed services;
- Link the child and family with services and coordinate the various service components; and
- Participate in treatment planning and ensure that all elements of the child's individualized service/treatment plan are addressed and services are provided.

CYS provides case management to all consumers based on the level of need and intensity of services required. The two levels of case management are:

- Basic case management: provided by the case manager/therapist who is part of the main program from which the child and family receive services (e.g., outpatient clinics, psycho-educational, therapeutic group home, supervised independent living, etc.).

- Intensive case management: provided to multi-needs, multi-agency involved children and family living at home, being discharged from acute inpatient services, and also those youth

who are entering or leaving residential treatment facilities. Multi-needs, multi-agency involved children (and their families) are considered to be the service priority due to the fact that they are either currently placed out of the home or at risk for such placement. Intensive case management is provided at the outpatient clinics. The intensive case managers coordinate and manage the interagency components of a child's individualized plan. As noted, the case management and monitoring functions for child/youth in residential placements performed by RPU are being transitioned to the appropriate DMH offices and programs.

Consumer Advocacy- Child, youth, and family consumer advocacy issues are the functions of the DMH Consumer and Family Affairs and Consumer Rights offices. Emphasis within CYS is placed on improving the present array of services offered to children, their families and caretakers. Some of the advocacy groups with which CYS collaborates include: the Family Advocacy and Support Association, Inc. (FASA); Judge David L. Bazelon Center for Mental Health Law; Mental Health Association of the District of Columbia; and the Community Partnership for the Prevention of Homelessness.

A central initiative of DMH will be the efforts of the DC CINGS Project to begin the process of rebuilding trans-agency relationships, integration/coordination and policies and procedures particularly as they relate to program planning, implementation, management, and service delivery for children and youth in more costly out of home placements (i.e., residential, hospital, shelter, group home, foster care). The Sub-Council of the Mayor's Intergovernmental Youth Collaborative will be used as the interagency governance structure to codify this effort in legislation and District rule making.

The D.C. CINGS Project also contains significant support in the form of funding to enhance the participatory roles of family and family organizations in the planning, implementation, evaluation, monitoring and provision of services as part of DMH efforts to make its services and provider network more accessible, accountable, effective and culturally competent.

In fiscal year 2003 DMH continued implementation of a new Management Information System (MIS). The future MIS will be comprised of an integrated network of systems including the Contract Management System, a Provider Management Information System, a Hospital Management Information System (MIS), and small specialized databases that will together be able to record data on any of the measures defined and specified to be included in the system. The new MIS will use state-of-the-art networking technology, fourth generation language development tools, data warehousing and mining technology, relationship database management systems, all of which facilitate easy incorporation of data elements for recordation and reporting. Critical to this effort will be the development of databases that will provide for the ability to appropriately share critical information across key child-serving agencies that are members of the Sub-Council Governance structure under D.C. CINGS. This information will consist of children's utilization data.

Community-Based Services for Children and Families

The DMH community-based system of care has as an integral systemic value the conviction that recovery and resiliency-based models of service delivery and intervention best serve the

consumer. A core precept of such models is the utilization of a Strengths-Based perspective, especially in the area of the service planning process (i.e., Individual Plan of Care). Although intuitively appealing and supported in the literature (DeJong & Miller, 1995) these models are difficult to operationalize, especially in an entrenched workforce that was intensively trained and grounded in the more traditional assessment/evaluation – deficit-focused model. Knowledge of how to operationalize the strengths-based perspective in practice is the most difficult aspect in implementing the perspective, and thus the key to retooling other parts of the deficit model (i.e., assessment, evaluation, service planning). Without extensive efforts to help the professional and family workforce gain knowledge, training and experiential practice in this model, all efforts to shift the paradigm in the system of care as to this perspective will prove unsuccessful.

Family Resource Center

The Department of Mental Health plans to continue its implementation of a Family Resource Center as an initiative for the State Mental Health Block Grant. The Family Resource Center is a product of the Child and Youth Services Administration's Family Involvement Task Force whose purpose was to generate ideas for the former Commission on Mental Health Services "District of Columbia's Wraparound" system of care grant submission. More specifically, the Family Involvement Task Force goal was to ensure maximum family involvement in the planning and implementation of the system of care.

The Family Resource Center would provide support services to meet the needs of both foster and natural families who are challenged by the care of children and youth with intense mental health or emotional needs in their homes. Family members and individuals from organized family groups will be recruited to fill these positions. Two family resource liaisons that are family members and a Family Coordinator (social worker or a mental health specialist) would operate the Family Resource Center. The development of the organizational structure of the center will be done in close cooperation with families and would include an array of, some of which include:

- Family Information Hotline;
- Family Outreach;
- Referral Services;
- 24 hour access to support;
- Transportation Stipends;
- Substance Abuse Support; and,
- After School Daycare Services.

The Family Resource Center would not duplicate existing services, but would rather expand existing resources and bring them closer to the community and consumers who utilize them. Family members will be hired and trained to provide informational, support and advocacy services, and would also staff the Family Hotline.

Children and their Families who are Homeless with Serious Emotional Disturbance

It is well understood that homelessness is a life circumstance that can place children and youth at risk for a number of problems such as exposure to violence, abuse and neglect, truancy and behavior problems in school that may result in serious emotional disturbance (i.e., anxiety,

depression, adjustment disorder etc.) Homeless children and their families are by definition a group that can easily "fall between the cracks" in the system of care. Further even when some services may be available it is difficult to reach these families and to subsequently link them and maintain contact with them as treatment continues. Critical in successfully reaching this population is how the service is delivered and by whom. DMH proposes to utilize the Family Resource Center and its Family Liaisons (parent/family members) as a family-based and culturally competent means to effectively outreach, link and maintain continuity of care to this important group of consumers. As such, DMH proposes to fund specialized training for family liaisons designed to provide them with the specialized skills and expertise that are necessary to successfully reach this population. In addition, DMH proposes to fund a related social marketing campaign design to increase sensitivity to the unique issues confronted by the homeless family with children and to increase awareness of how to obtain services.

Programs for the Homeless

Homeless Outreach Program (HOP) – The HOP consists of four staff in addition to the DMH Homeless Services Coordinator (one RN, one PT psychiatrist and two mental health specialists) that provide, engagement services, crisis assessments and access to appropriate community services as well as inpatient care. The team maintains structured relationships with shelters, outreach programs and other kinds of homeless services and responds as needed. The team has a regular presence at these programs on a weekly basis and works with homeless program staff to identify appropriate plans for consumers who are homeless and mentally ill. Each member of the outreach team also provides education and consultation services to homeless programs on a variety of issues, assists in securing necessary paperwork for referrals, and shares resources and information about mental illness. The team also assists with regular trainings of shelter and homeless program staff. This program was relocated from the Comprehensive Psychiatric Emergency Program to the auspices of the Homeless Services Office during fiscal year 2000.

The Homeless Services Coordinator who leads the HOP Team also provides service and systems integration activities with the homeless services provider system and other systems that address the needs of people who are homeless in the District.

In fiscal year 2002, the team expanded the range of services that was offered. This will include psychiatric treatment. The new psychiatrist added to the team now serves as the Clinical Director of Homeless Services for the DCCSA.

Homeless Support Teams (HSTs) – The HSTs have been integrated into the MHRS system as Assertive Community Treatment (ACT) Teams. ACT is an intensive, integrated, rehabilitative, crisis, treatment and community support service provided to adult consumers with serious and persistent mental illness by an interdisciplinary team, with dedicated staff time and specific staff to consumer ratios. The services provided by the ACT Team include: medication prescription, administration, and monitoring; crisis assessment and intervention; symptom assessment, management, and individual supportive therapy; substance abuse treatment for consumers with co-occurring addictive disorder; psychosocial rehabilitation and skill development; social and

interpersonal skill training; and education, support, and consultation to consumers' families and their support system which is directed exclusively to the well-being and benefit of the consumer.

Drop-In Centers - There are two drop-in centers operated as part of the DMH adult mental health system. Our House drop-in center, operated by Psychiatric Outreach Services, Inc., is located in the downtown area of Washington D.C. and is open for operation from 8:00 A.M. until 6:00 A.M. daily. This program provides services that meet the basic needs of persons who are homeless i.e. lunch, lockers, showers, and laundry facilities. Low demand support, co-occurring disorder (MISA), psycho-educational and motivation groups are also provided. Staff at the drop-in include mental health clinicians who work to engage persons in need of mental health services from beginning to assist clients in meeting basic needs, and then beginning to help them start to address other life domain needs such as accessing financial and medical benefits, housing, and mental health treatment. Staff members also work to address life skills and problem-solving skills as engagement into services proceeds. This program does not need a referral and is one of the key access points for persons who are homeless and mentally ill entering the DMH system of care. Partial funding is secured through the Federal Path grant.

Our Turn Inc., a consumer operated non-profit in the District, operates a second drop-in center for persons who are homeless and mentally ill in the District. Services to meet the basic needs of persons who are homeless are provided as described above. Staff members who have been homeless at one time assist in engaging these individuals who are homeless and often difficult to engage to begin accepting services.

Fourth Year Post Graduate Psychiatric Residents- DMH has an active residency program, which identifies up to six residents per year to be assigned to shelters for several hours weekly. The Homeless Services Coordinator assigns the resident to an appropriate homeless services setting where the resident will have access to people in need of psychiatric services. The residents learn skills in engagement and assessment while providing appropriate psychiatric services to those individuals willing to accept them. It is planned to expand this program now that the HOP psychiatrist can provide supervision to these residents.

Shelter Plus Care- This program is a federally- funded program providing housing and support services to individuals who are mentally ill, homeless and may have co-occurring disorders such as substance abuse and HIV/AIDS. Sponsor-based housing for which the Department provides the match in the form of services, serves approximately 120 people annually at a cost of 1,889,000. The applicant and administrator for these projects is the Community Partnership for the Prevention of Homelessness. Many of DMH adult service provider agencies operate Shelter Plus Care supported housing.

A Supportive Housing Program grant to open two eight-bed transitional supported houses for people are homeless and mentally ill has been awarded and funding to open these houses has just been drawn down by one of DMH's CSAs, The Green Door. DMH has also assisted these agencies in obtaining Steward B. McKinney funds to provide the necessary support service funds in addition to those provided by the District. In the future, the method that the service match funding is captured has to be updated to keep in line with the new MHRS financing system and certification standards for the MHRS providers. It is now required that consumers have a choice

in the CSA which provides their services. Changing CSAs cannot result in consumers having to leave housing. The plan is to collect the match by capturing the District dollars billed for services provided by any provider in the DMH system providing services to individuals in Shelter Plus Care housing as opposed to the current method where Shelter Plus Care grants are written with services and match only being allowed from the one sponsoring agency.

Home First II and DRSP- The DMH manages two rental subsidy programs that assist clients in living independently in the community. A key priority of these programs is to subsidize the rental costs for people who are homeless. Currently rents are paid for these individuals in both independent apartments and single room occupancies (SROs) as well as Transitional Group Housing. Flexible funds for furnishing, apartment set-up, and unexpected emergencies are also provided. It is hoped to increase the funding and capacity of this successful initiative that has demonstrated that persons who are seriously mentally ill in the District, even those who have been street homeless, can live successfully in independent settings and hold their own leases.

Funding for Homeless Programs – The DMH uses Federal grant funding to supplement services to persons who are mentally ill and homeless. These funds have included the Path Grant ($300,000 per annum), Shelter Plus care and the Mental Health Block Grant. Services provided with these funds include the drop-in center, Outreach services, and rental subsidies. It is hoped some funds can be earmarked an additional year to assist in expanding the outreach services and mental health services provided by and collocated at homeless service provider agencies not traditionally funded by or integrated with the DMH system of care.

Treatment Planning Process

The treatment planning process is the center of service delivery. Individual treatment planning begins in the Acute Care program with:

- Comprehensive interdisciplinary assessment including psychiatric and medical histories,
- Mental status examinations,
- History of substance abuse, and
- Evaluation of the consumers' family, work, and social relationships.

The CSA in collaboration with the inpatient treatment team develops an Individual Recovery Plan (IRP) involving the consumer, treatment team staff from the hospital and community and any significant others in preparation for their return to living in the community. It is the CSA's responsibility to develop this plan based on the consumers choices and needs through determining mutually agreeable treatment goals.

Trends in Information Management

During fiscal year 2002, the DMH Management Information Systems Branch implemented key objectives stipulated in the Transitional Receiver's Plan. These included the implementation of a Wide Area Network (WAN), deployment of state-of-the-art personal computers configured for Internet and email access, and the implementation of the Contract Management System.

The establishment of the WAN and the deployment of personal computers configured with state-of-the-art software has set the stage for the implementation of the Contract Management System (CMS) and other information system applications that comprise the DMH's management information system. The future MIS, which will be comprised of an integrated network of systems including the CMS, a Provider Management Information System, a Hospital Management Information System, and a small-specialized database will together be able to record data on any of the measures defined and specified to be included in the system. The new MIS will use state-of-the-art networking technology, fourth generation language development tools, data warehousing and mining technology, relational database management systems, all of which facilitate easy incorporation of data elements for recordation and reporting.

Departmental Training

The Transitional Receiver's Final Court-Ordered Plan (March 2001) required the establishment of a departmental Training Institute "…to develop strong working relationships with local universities and other professional resources, and to provide a continuous learning environment for consumers, community stakeholders, staff and providers." The Final Court-Ordered Plan also emphasized that the Department of Mental Health (DMH) would work with organized labor to find effective ways to manage the ongoing re-training and redeployment of staff. The Transitional Receiver noted further that all staff rendering services in the new system would be required to demonstrate knowledge and performance competencies in a range of areas. The DMH Training Institute should be the axle in the wheel of workforce development in the dynamic system of change.

Several training tracks were designed with an array of educational sessions within each track:

- Business/Financial;
- Clinical (Adult and Youth);
- Cultural Competence;
- Consumer Recovery; and
- MHRS Certification.

IV.NEED PROJECTIONS FOR CAPACITY AND SERVICES

Barriers to Access

There are a number of barriers that need to be addressed to improve access to mental health services by persons who are homeless and mentally ill in the District. The MHRS rehabilitation and recovery model of care now requires that DMH certified MHRS providers provide a minimum of 50% of the services in other than office based settings. The MHRS service design now being implemented emphasizes continuous responsibility for those with SMI, and allows for virtually unlimited reimbursement for outreach and engagement services to provide increased incentives to provide more and better services to persons who are homeless. Increasingly services must be provided outside of the normal working day.

Competencies in engagement have been developed in some of the specialized homeless service programs but need to be further developed across the DMH system of care. Integration of mental health services with homeless service providers where many of the people who are homeless are sheltered, eat, and receive services has been poor. In fact many providers in the homeless provider system, as in many other cities, report firing the mental health system because of perceived and real lack of responsiveness and competencies in serving this population. DMH intends to develop initiatives in these areas over the coming year(s).

Identified Gaps in Services & Unmet Needs

Several system and program gaps have been identified:

- Currently there are no MHRS non-traditional child/youth service providers. Efforts are underway to attract providers of non-traditional services needed for wraparound model driven IPC treatment planning and service delivery process, to divert children/youth from acute inpatient hospitalization and residential placement.
- Gaps exist in the appropriate transition services for children/youth with serious emotional disability that are court involved, to divert from out-of-home placement and who may also be returning from out of state residential treatment or leaving acute inpatient hospitalization.
- There is need for an increase prevention services offered through the Authority, Core Services Agencies' and HMO/ MCO Behavioral Health Plans, by working with providers to develop education and informational programs that would be offered directly to the consumer on topics designed to increase awareness, educate and improve mental and emotional well being of consumers.
- A need exists for capacity building in the area of community forensic mental health service delivery.
- There is a lack of an established communication pathway and practice guidelines that govern interface with the criminal justice system.
- There is a lack of developed system-wide performance standards for delivery of Options Program services.
- There is a need to address the emotional trauma experienced by children of mothers who are incarcerated.
- There is a need to establish the ability to offer Continuing Education Units (CEUs) to all eligible participants and to expand the number of children, youth and family track sessions for the fiscal year 2003 Fall and Spring Training Series.
- There is need to broaden the range of cultural competence topic areas offered (e.g., Latinos, Asians, homeless, sexual/gender identity, hearing impaired/deaf, socioeconomic/class issues, criminal justice settings).
- Gaps in training exist and there needs to be development of different levels of subject matter sessions Training Institute developing tracks to address varying participant skill abilities (introductory, intermediate, and advanced levels) and an increase in the number of "Train-the-Trainers" staff development experiences.
- There is also a need to increase the number of training sessions for re-training the current DMH workforce at all job category levels to be consistent with the Transitional Receiver's

Plan for the DMH Training Institute requiring new skill competency sets for employees and evaluate the competency of training participants on new skills and information within the context of implementation to their respective job performance. Training should be an element of all employee performance standards and appraisals.

- There is no Medicaid funding for substance abuse treatment for the under 21 population, a service that is available for adolescents through Medicaid in neighboring states - Virginia and Maryland.

V. CRITERIA AND STANDARDS

The Department developed and implemented a comprehensive set of service standards. To date, 11 providers have been certified as CSAs. Additionally, a number of provider agencies are in the application and certification process. A number of specialty and sub-providers who are affiliated with the CSAs such as providers of ACT and Community Support services have also been certified. The Department is in the process implementing new scopes of work, rates, and MHRS certification standards and certification for the entire District funded (non-Medicaid) MHRS services.

The District's Department of Health State Health Planning and Development Agency (SHPDA) uses the following criteria in their review of certificate of need applications.

A. Availability

Availability is defined as the need projection indicating the supply of resources in relation to the need or the demand for resources. The availability of mental health services include:

- Hours of operation convenient for the patient;
- Availability of appointments within two weeks of request;
- On-site integration of services;
- Availability of enabling and support services – transportation, language interpretation and outreach, and;
- Referral to appropriate specialty care as a part of continuity of care

Providers must also have a mechanism, such as an on-call psychiatrist or equivalent health professional or a staffed advice line, which allows patients to obtain urgent advice during hours when the office is closed.

B. Accessibility

Accessibility is the measure of the ease of entry of services for the consumer.
Ease of entry includes:

- Affordability of services;
- Location of services, and;
- Travel distance

The Department of Mental Health's standards of care for mental health services incorporates requirements for certified clinics to treat all patients who present for care without regard to that person's income and offer a sliding fee scale based on income. Uninsured patients whose income is below one hundred percent (100%) of the federal poverty level would either not pay or pay a nominal fee. Additionally, the standards address the patient population to ensure that District of Columbia residents whose family income is 200 percent of the federal poverty level have access to healthcare. The standards also state that the organization's patient base must include at least one-third of the low-income population.

C. Continuity

Continuity is the structure, coordination and delivery of services on a continuous basis and in a timely manner. Continuity of care includes:

- Plan of care based on the knowledge of the patient's medical history;
- Knowledge of accessing appropriate level of care when needed;
- Receiving care in a timely manner, and;
- Providing appropriate referrals and follow-up

The facility should also have the ability to provide continuity of care through an integrated referral system that included arrangements for follow-up for in-patient and specialty care and social support (i.e. home health services, rehabilitative services, dental services, vision services, pharmaceutical services, health education services, language interpretation, therapeutic services, in-patient hospital services and medical specialist).

D. Quality

Quality is defined as the degree of excellence characterized by levels of technical competence, appropriateness, safety and beneficial impact. Quality of care includes:

- Patient perception of the care received;
- Appropriate professional credentialing of health care providers;
- Conducive environment;
- Culturally-competent staff;
- Accreditation by a relevant professional organization, and;
- Professional practice standards

Furthermore, the plan shall include a methodology for reviewing the entire range of care provided by the facility. Organizations seeking certification from the District of Columbia Department of Health will be required to submit a written continuous quality improvement plan that includes measurable objectives and a timetable for implementation. The plan will address the quality of both clinical care and non-clinical services including availability of care, accessibility of the facility, coordination of care and continuity of care.

Certified mental health facilities will provide healthcare under the direction of a psychiatrist or medical director who is a licensed practitioner in the District of Columbia. The medical director

must have the authority to direct the clinical staff, to hire and remove staff, to implement the Continuous Quality Improvement Plan and to establish health maintenance schedules and practice guidelines.

E. Acceptability

Acceptability is defined as the degree of satisfaction of the services to the community and its users. Acceptability includes:

- Convenience to the user;
- Positive provider attitudes;
- Equity in services;
- Problem resolution, and;
- Institutional respect for cultural and religious differences

Acceptability is important in providing opportunities to determine the level of satisfaction experienced by the consumers.

F. Cost

Cost is defined as the total expenses and economic consequence of the provision of services, including provider cost, consumer cost, opportunity costs and societal costs. Costs include:

- Minimal or no fee for services to the underserved residents
- Posted schedule of discounted or waived fees
- Pharmaceutical discounts, i.e. generic medications where appropriate

Clinics would be required to demonstrate their ability to provide uncompensated care to medically vulnerable populations and have a written policy.

In addition, emphasis should be made on utilizing Medicaid certified providers in the District rather than on sending District youth and monies to other states. Furthermore, there should be a disincentive for referring to out of state providers who do not participate in the DC Medicaid program.

VI. GOALS AND OBJECTIVES

Goal 1:
To provide supportive housing through cost-effective and efficient development and financing structures.

Objectives:
1.1 Increase supportive housing and consumer access to housing subsidies and the number of housing units by at least 50% over the fiscal year 2002 level for persons who are seriously mentally ill.

Goal 2:
To improve accessibility to publicly funded community services for all District residents with mental illness, and a co-occurring substance abuse disorder.

Objectives:

2.1 Expand the integration efforts with the Addiction, Prevention and Recovery Administration (APRA) and the Department of Correction for persons with co-occurring disorders.

2.2 Adopt the Comprehensive, Continuous, and Integrated System of Co-Occurring Services (CCISC) across the appropriate agencies and departments in the District of Columbia.

2.3 Implement the CCISC Plan developed by the Joint Core Leadership Group with the technical assistance of Zialogic, Inc.

Goal 3:
To improve and enhance trainings to providers of mental health services and community support services regarding competencies in working with persons who are homeless and mentally ill.

Objectives:

3.1 Enhance quarterly training sessions to homeless services providers, ACT and Community Support Workers regarding competencies in working with persons who are homeless and mentally ill.

3.2 Provide technical assistance and infrastructure funding to culturally diverse and neighborhood based service providers to become certified MHRS providers.

3.3 Complete the transfer of full supervisory responsibility for PGY4 residency training program to HOT Homeless Services Coordinator and HOT Psychiatrist.

3.4 Broaden the range of cultural competence topic areas offered in the training curriculum to cover Hispanics, Asians, the homeless, sexual/gender identity, hearing impaired/deaf, socioeconomic/class issues, and the criminal justice settings.

Goal 4:
To establish programs, services, and coordination efforts that will support the diversion of adults with serious mental illnesses from incarceration to appropriate mental health services and resources.

Objectives:

4.1 Develop a coordinated response model and a diversion initiative between DMH and the Metropolitan Police Department.

4.2 Expand the Options Program (diversion from incarceration for offenders with mental illness) services within the community-based delivery system.

4.3 Develop a Plan to enhance collaboration with criminal justice agencies to improve identification of service needs to aid in diversion of mental health consumers.

4.4 Determine the needs within the community mental health system for service delivery to offenders returning to the community from prisons and jails.

4.5 Develop and implement a plan to address the identified needs of offenders returning to the community from prisons and jails.

Goal 5:
To maximize the use of Medicaid funding to support community-based services for adults with serious mental illnesses and children with serious emotional disturbances.

Objective

5.1 Develop a standardized tracking mechanism to ensure that Medicaid funding is maximized to support community-based services.

Goal 6:
To improve continuity of care by establishing a baseline number of children/youth who have utilized the comprehensive community-based mental health system, including out-of-state placements.

Objectives:

6.1 Develop and implement an inter-disciplinary monitoring instrument to ensure intense case management and outreach services linkages are provided to facilitate proper transition of individuals back to their home communities.

6.2 Establish a baseline number of children/youth registered in the mental health system actually placed in out-of-District residential facilities through the Multi-Agency Planning Team (MAPT) process.

6.3 Establish a baseline number of children/youth committed to the Youth Services Administration due to untreated mental health disorders as identified by the Alternative Pathways Project.

Goal 7:
To develop interventions that target children, youth and families in the District of Columbia public and Charter Schools through a comprehensive, multi-faceted and integrated school-based mental health program.

Objectives:

7.1 Provide early prevention for youth and their families by offering school-based mental health services in at least 25-30 public/charter schools.

Goal 8:
To develop interventions that address the mental health and related needs of children to divert them from the juvenile justice system.

Objectives:
8.1 Implement the Alternative Pathways Project with the aim of diverting children with significant mental health issues from entering the juvenile justice system in a detained or committed status.

Goal 9:
To develop a system of care for children with or at risk for serious emotional disturbances in the District of Columbia.

9.1 Implement the comprehensive trans-agency imitative, D.C.CINGS Project, as an effort to build true trans-agency organizational infrastructure for policy and procedure, as well as, service provision.

Goal 10:
To develop comprehensive adult and child services that enhance the transition from inpatient to community-based services and reduce hospital length of stays.

Objectives:

10.1 Determine the impact of the Clinical Manager interface with Saint Elizabeths Hospital staff and acute care facilities for children to assure continuity of care and to reduce the number and length of stay for acute hospitalizations.

10.2 Evaluate the effectiveness of the Acute and Continuing Care Programs at Saint Elizabeths Hospital and other acute care facilities for children in promoting recovery and resiliency to promote reduced reliance on hospital services.

Goal 11:
Enhance the coordination of regulatory agencies when site visits are conducted to determine the level of compliance with appropriate standards/protocols

Objectives:

11.1 Participate in a work group to review the process of regulatory site visitations to organizations and agencies that are regulated by the Department of Health.

11.2 The work group will streamline the regulatory site visitation process to maximize the number of agencies conducting the visits and minimize the number of visits.

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